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MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN? S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children?s Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN? S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Texas
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

Don A. Gilbert
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Jason Cooke	Position/Title: Director of Medicaid/CHIP Operations
Name: Don Green	Position/Title: Chief Financial Officer
Name:	Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ▪ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ~ Providing expanded benefits under the State?s Medicaid plan **(Title XIX)**; **OR**

1.1.3. ~ A combination of both of the above.*

* Phase I (Medicaid "Phase-In" children) covered under the original Texas SCHIP state plan have been completely phased in to Medicaid as an eligibility group. However, the state would reserve the right to continue to claim EFMAP for any outstanding and unpaid Medicaid claims for that group for dates of service prior to their conversion to a regular Medicaid FMAP group.

1.2 ▪ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 ▪ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date:

This Compliance SPA amendment reformats Texas' existing CHIP state plan covering Phase I and Phase II children. In general, the effective date(s) are the same as the original CMS-approved effective dates for Phase I (Medicaid coverage for phase-in children) and Phase II (separate, state-designed CHIP coverage up to 200% FPL).

Subsequent amendments to the original CHIP state plan (related to the Phase II program), have been incorporated into this new state plan template, and are effective per their CMS-approved effective date. The amendments to date are listed below:

- **CHIP Method of Finance Change – Approved 12/13/01, Effective 9/1/2001**
- **CHIP Cost Sharing Changes- Approved 5/1/02, Effective 3/1/02**
- **CHIP Car Seat Initiative- Approved 11/25/02, Effective 6/15/02**
- **CHIP Community Health Worker Initiative – Pending (will be effective the same date of final Compliance SPA approval)**

Implementation date: May 1, 2000 (CHIP Phase (II)

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

The estimated population of children under age 19 in Texas for 1998 was 5,843,964. Approximately 2,728,768 were non-Hispanic white, 2,202,555 were Hispanic, 764,295 were African-American, and 148,346 were of other race / ethnicity. The most recent u s. Census data (for calendar year 1997) show 16.75% of the Texas population living below the federal poverty level. Applying that percent to the total 1998 state population of 19,649,800 reveals that approximately 3,291,342 residents had family incomes below the federal poverty level that year.

Data from the current population survey (CPS) for Texas collected in March of 1997 and March of 1998 were used to estimate, as of 1998, the health insurance coverage type of children under the age of 19. For the 5,843,964 Texas children under age 19 in 1998, insurance coverage type is estimated as follows*:

Coverage Type

	Medicaid	Other-Non Medicaid	Uninsured
Percent	18.9%	56.9%	24.2%
Number	1,106,858	3,325,200	1,411,907

Medicaid is the public health insurance program generally available in Texas. There are several public-private partnerships in the state (see 2.2.2 below).

Based on the CPS data, estimates of the number of uninsured Texas children under the age of 19 for 1998 by age group are as follows*:

Age Group	Number of Children	Percent Uninsured	Uninsured
0-5	1,934,936	21.0%	406,658
6-14	2,692,492	24.1%	648,560
15-18	1,216,536	29.3%	356,689
0-18	5,843,964	24.2%	1,411,907

The breakdown, by percent of poverty category, of Texas uninsured children under the age of 19 as of 1998 is as follows*:

Percent of Poverty Category	Uninsured Children Under 19
At/Below 100%	547,208
101% through 150%	302,947
151% through 200%	196,161
Above 200%	365,591

* Some sums may not equal total due to rounding.

The CPS-based estimates for 1998 show the following detailed breakdown of Texas uninsured children under the age of 19 in 1998 by age group and percent of poverty category:

Percent of Poverty Category

Age Group	At/Below 100%	101% through 150%	151% through 200%	Above 200%
0-5	173,047	82,269	58,464	92,878
6-14	231,426	161,751	83,264	172,119
15-18	142,735	58,927	54,433	100,594
0-18	547,208	302,947	196,161	365,591

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Children are identified and enrolled in Medicaid through a variety of mechanisms.
Medicaid applications are processed in offices throughout the states including approximately 500 local Texas Department of Human Services (TDHS) offices, in hospitals, and in clinics. Additionally, TDHS conducts telephone interviews and home visits as needed by clients

Out stationed Eligibility Staff - TDHS outstations eligibility workers in clinics and hospitals. This staffs perform eligibility functions as well as screening functions for potential Medicaid and SCHIP eligibles. There is approximately 300 staff out stationed in 190 facilities. The number of out stationed eligibility staff in a facility is a function of the volume of eligibility determinations made at

the facility. In some cases, disproportionate share hospitals (DSH) and Federally Qualified Health Centers (FQHCs) fund the state share of salary and benefits costs associated with staff above and beyond those required by federal law. Facilities that are not DSH hospitals or FQHCs can contract with TDHS for eligibility specialists and appropriate support staff to be placed in the facility. Under these contracts, the facilities also reimburse TDHS for the state share of the employee's salary and benefits.

TDHS Hotline (1-800-252-9330) - The Hotline primarily handles complaints. However, when a client calls and relays information about potential eligibility, or inquires about programs for which they may be eligible, the client is referred to the correct local office or, if appropriate, to a designated regional contact.

TDHS Administrative Services (512-438-3280) - Clients and potential clients who call TDHS State Office are referred to the administrative services unit. Some of these calls may be from potential clients asking for instructions/assistance in applying for benefits. Callers are referred to local TDHS offices as appropriate.

TDH Hotline (1-800-252-8263) The hotline handles calls for Texas Health Steps (Texas' EPSDT program)

Blue Pages Listings - Current information for local TDHS offices is contained in local telephone directories in the government blue pages section. This information is broken down by programs and is updated as needed.

Worldwide Web Sites - TDHS maintains an agency home page that contains information about what types of benefits are available throughout the agency and also contains links to home pages for each of the TDHS regions. The regional home pages contain listings of local offices, and the services available at each of the local offices.

Food Stamps – Individuals applying for food stamps are tested for eligibility for Medicaid during the same interview.

Temporary Assistance to Needy Families (TANF) - Individuals eligible for TANF are made Medicaid eligible by virtue of their certification for TANF. Those who apply and are determined ineligible for TANF are tested to determine their eligibility for Medicaid under other eligibility categories. Former TANF recipients receiving transitional Medicaid are sent an automated notice telling them to contact their local TDHS office if they wish to reapply for Medicaid when the transitional Medicaid ends.

Newborns of Medicaid Eligible Mothers - Enrollment in Medicaid is automatic

for the majority of newborns of Medicaid-eligible mothers. When the medical facility notifies a TDHS centralized unit about the birth of the child to a Medicaid-eligible mother, the TDHS unit establishes eligibility for the child. An automated system then notifies the child's mother, designated providers, and the child mother's caseworker about the child's eligibility. These newborn children are also included in the Texas Health Steps outreach (see below).

Title V - In the Texas Title V Children with Special Health Care Needs (CSHCN) program, known as the Chronically Ill and Disabled Children's Services Program (CIDC), most clients are required to apply to Medicaid or SCHIP before they receive full CIDC eligibility. Some are enrolled in Medicaid as a result. Those who reach a certain expenditure level for CIDC services are required to apply again to Medicaid, with the emphasis on eligibility for the Medicaid Medically Needy Program, the spend down program under Title XIX.

The regional Title V CIDC social work and eligibility staff and the CIDC case management contractors help families with CSHCN to obtain Medicaid eligibility when appropriate.

In Title V Maternal/Child Health (MCH) contracts across the state, children who, after eligibility screening, appear to be eligible for Medicaid, are required to apply for Medicaid in order to continue to receive MCH services in the contractors' clinics. The contractors include many local health departments as well as hospital districts and other providers. An automated screening tool, Texas Eligibility Screening System (TESS), is used by many of these providers to screen for possible eligibility for Medicaid, CIDC, and other programs. The client must then go on to actual Medicaid eligibility determination, if the TESS screen indicates they may be Medicaid eligible.

Supplemental Security Income - SSI eligible persons are automatically enrolled in Medicaid in Texas. The Texas Rehabilitation Commission Disability Determination Divisions make disability determinations for SSI.

Foster Care - For children who are removed from their households by court order through the Texas Department of Protective and Regulatory Services (TDPRS), Medicaid is provided through foster care if the child was eligible for Medicaid prior to being removed from the household or if the child is determined to be Medicaid eligible by TDPRS standards. Medicaid is also provided, under Medically Needy and TANF limits, to children under 18 placed by a district court in the managing conservatorship of the Texas Department of Protective and Regulatory Services (TDPRS) as a result of findings of abuse or neglect by TDPRS.

Child Support - The Child Support Enforcement Office of the Attorney General

seeks out the non-custodial parent for financial and/or medical support to supplement and/or replace state liability. This office also processes through the Third Party Reimbursement (TPR) system to seek premium reimbursement for cases where medical coverage is provided.

Local Mental Health Authorities (LMHAs) - Under the authority of the Texas Department of Mental Health and Mental Retardation, LMHAs are required to do outreach to identify clients with serious mental illness and mental retardation. The LMHAs vary in the amount and types of outreach conducted. Outreach activities may include: public announcements; distribution of brochures in targeted areas, such as doctors' offices, schools, and juvenile courts; public forums; or public festivals.
At intake, information which may indicate Medicaid eligibility is gathered by the LMHA. Individuals who appear to be Medicaid eligible are then referred for Medicaid eligibility determination. If the individual needs assistance with this referral, the LMHA will assist.
LMHAs may have out stationed TDHS Medicaid eligibility workers on staff who do the Medicaid eligibility determinations on site.

Texas Health Steps - Texas Health Steps outreach efforts are aimed at encouraging use of services (program participation) by enrolled THSteps clients. Texas Health Steps communicates with Medicaid eligible families on the state level as well as on the regional and local level through a statewide system of TDH staff and contractors using the following tools:

- over 435,000 informing letters per month;
- a variety of brochures and other handouts in English and Spanish for recipient and provider use;
- home visits, telephone calls outreach at places where clients may be found, and efforts targeting specific groups such as migrant workers and newly enrolled Medicaid recipients;
- a single statewide toll-free number (1-877-THSTEPS) that is routed to the appropriate regional outreach location.
- regional provider newsletters which help to keep Health Steps providers informed of developments in the program;
- regional provider relations staff who help recruit and maintain Health Steps and Medicaid providers, supplementing the provider relations activities for which TDH contracts with NHIC;

- the Medicaid Bulletin, which provides information to all Medicaid providers; and

- the Medicaid managed care enrollment broker, whose staff helps educate clients as they are enrolled in health plans.

In the course of promoting use of EPSDT service, THSteps staff and contractors inform interested families of the way to apply for Medicaid for other children.

Babylove Line - The Babylove toll-free hotline, funded by Title V, provides information and referrals for families who call in, including referrals to Medicaid and Title V MCH and CIDC services.

Texas Information and Referral Network – The Texas Information and Referral Network (TIRN) at the Health and Human Services Commission, coordinates a statewide network of state and local contact points to provide information regarding health and human services in Texas, including Medicaid.

Pursuant to SB 445, 76th Texas Legislature, Texas extends general revenue-funded SCHIP coverage to non-citizen children who would be SCHIP eligible but for their immigration status. In addition, state employee children who otherwise meet SCHIP eligibility criteria are eligible for enhanced state-funded subsidy of their coverage through the Uniform Group Insurance Program offered to state employees.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Texas has a variety of established programs and programs under development which involve private-public partnerships in providing health insurance coverage to uninsured children.

The Caring for Children Foundation of Texas, Inc. provides a package of health care benefits for uninsured children ages 6 to 18 who are enrolled in school with family incomes up to 133 percent of the federal poverty level. Children must have applied for but been denied Medicaid coverage within the previous three months. Service costs are funded by donations from companies, religious groups, community and civic organizations, employee groups, and individuals. Administrative and operating costs are paid by Blue Cross Blue Shield of Texas, Inc. Benefits include doctor visits, routine immunizations, outpatient diagnostic tests, outpatient surgery, outpatient emergency illness and accident

care, and prescription drugs. There are no costs to the family except for a $5.00 co-pay for each prescription drug.

More than 6,100 children have been enrolled for this program, but 1,500 are on the waiting list because there are not enough sponsors. Outreach to uninsured children is conducted through distribution of bilingual pamphlets and applications by public schools, school nurses and counselors, churches and synagogues, local businesses, doctors' office, hospitals, pharmacies, and Medicaid eligibility offices across the state.

The Laredo Project is a school-based pilot health insurance program created by the Texas Legislature in 1995 to cover uninsured children up to age 13 with family incomes up to 133 percent of the federal poverty level who are not eligible for Medicaid. A local elementary school in Laredo, Texas, was the initial site chosen for the pilot. The project has been expanded to include the entire Laredo Independent School District and the United Independent School District.

The pilot is administered by the Texas Department of Health (TDH) through a grant to the Laredo Health Department. Health coverage is provided through a health maintenance organization (HMO). In addition to state appropriations, funds for coverage were donated by the HMO and local businesses. Funds from a foundation have been made available to provide emergency premium payment assistance. The school has played a key role in implementing the pilot. It became the focus for communication and outreach to families and the enrollment center for the pilot. The school also provided bilingual, appropriate reading level marketing and enrollment materials. Other in-kind services were provided by local businesses.

The pilot provides low-cost comprehensive coverage and has been in operation for one year. Currently 500 children are enrolled. At least 20 percent of those screened during the first year were found eligible for and enrolled in Medicaid. The project is scheduled to end in August 2000.

The Texas Health Insurance Risk Pool was funded by the Texas legislature in 1997 to provide the administrative structure for ensuring that health coverage is available to persons unable to otherwise obtain coverage because of their medical history or because they lose employer coverage. Coverage is automatic for uninsurable persons with certain diagnoses, such as metastatic cancer, leukemia, diabetes, epilepsy, and sickle cell anemia. The Pool began operation on January 1, 1998.

An extensive preferred provider network is utilized by the Pool. In addition, a prescription drug benefit is included with the policy. Participants can select a $500 deductible package or a $1,000 deductible package. Premium rates are based on age, sex, area of the state, and smoking status. Although premiums up to

200 percent of standard risk rates may be charged, initial premiums were not set that high. At present, premiums for children to age 18 range from $67.00 per month to $139 per month. Benefits include inpatient and outpatient care and are limited to $1 million over a lifetime. Children are eligible for Pool coverage, either as eligible Pool applicants or as dependents of eligible Pool applicants. As of the end of April 1999, 4,232 Texans were covered by the Pool, including 458 children.

The Community Access To Child Health (CATCH) The CATCH Program is a program of the American Academy of Pediatrics funded by the dues of AAP members. There are also funds for CATCH planning meetings at the chapter level nationwide, which are supported by physician donations to the Friends of Children Fund and by funds from Wyeth Lederle Laboratories. The purpose of the CATCH program is to assist public-private partnerships in local communities to identify and resolve local problems of children's access to health care. Projects include providing health care services for children living in the colonias (rural developments along the Texas-Mexico border which frequently may not have basic amenities such as running water) and case management for very low birth weight babies.

The Healthy Tomorrows Partnership for Children Program is a collaborative grant of the federal Maternal and Child Health Bureau and the American Academy of Pediatrics for local entities, such as local health departments, county hospital districts, and community health centers that are supported in part with state funds to increase access of mothers and children to health services. Projects include providing direct health care, prevention of sexually transmitted disease among minority youth, and improving the health status of medically indigent, low birth weight infants.

Two public programs identify children who could benefit from a private-public partnership. The Texas Medicaid program through the Health Insurance Premium Payment Program (HIPP) pays health insurance premiums for Medicaid eligible children. HIPP works with other state agencies, private employers, and private health coverage providers to ensure that Medicaid eligible children are able to take advantage of health coverage to which they have access. Given the broader scope of Medicaid benefits relative to the typical defined benefits package, children are able to take advantage of both public and private resources in receiving the services they need.

The Texas Title V program for children with special health care needs (CSHCN), the Chronically Ill and Disabled Children's Services program (CIDC), has a similar program that pays private health coverage premiums, when doing so is cost effective for CIDC and when the family is unable to afford the premiums. This program serves children with family incomes up to 200% of

the federal poverty level.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))
Linkages established with other public/private health insurance partnerships provide opportunities for collaboration and mutually supportive operations.

Coordination with Medicaid is achieved through coordinated outreach efforts and a joint children's application. Outreach efforts are coordinated with organizations such as Insure-a-Kid as well as contracts with fifty local, community-based organizations (CBOs). The CBOs were selected based on their local expertise and experience with low-income populations. SCHIP enrollment information is routinely shared with Texas' Title V agency in order to coordinate program benefits. Outreach efforts are also coordinated with local family courts with jurisdiction over medical support orders. Texas is also implementing a SCHIP premium assistance program, to better coordinate public and private insurance resources. Texas' SCHIP coordination efforts are ongoing, but appear successful, as Texas' SCHIP enrollment growth rate was among the fastest in the nation.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

Child health benefits are delivered through managed care models, including an HMO model and an exclusive provider organization (EPO)model primarily in rural areas of the state . . In the HMO & EPO models, the state contracts to deliver health care services, relying on managed care principles that will include a “manager of care” or “medical home” and utilization controls on inpatient hospital and certain other services in the case of the HMOs model and the latter only in the case of the EPO.

The same requirements are applied to both HMOs and the EPO .

The SCHIP procurement of health plan services is aligned as closely as possible with other plans, such as Medicaid and the Title V CSHCN program to improve continuity of care. Enrollees are given a choice of at least two plans whenever possible and Medicaid plans are given extra consideration in the procurement of SCHIP health plans.

Dental services are provided on a fee-for-service basis thru a dental indemnity carrier.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Under the HMO/EPO model, plans are required to provide the range of children’s health services for a contracted per member/per month cost determined through actuarial analysis. The state monitors utilization of HMO/EPO services as part of its overall monitoring program. Please see section 7 for more information on the state’s monitoring efforts.

The HMO model includes a number of utilization management controls. Inpatient hospital stays and other services determined by the Medical Director are subject to prospective review for medical necessity and appropriateness of proposed care before services can be rendered. Clients are required to obtain authorized referrals from their

primary care providers to other professional providers. The state or its designee also conduct retrospective utilization review activities to examine services to clients directly provided by the network's primary care provider specialty, services performed with authorization, and other services such as emergency room services. The same controls are used in the EPO model, except that the EPO operates without a gatekeeper function being performed by the HMO model's PCP.

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the states Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

These standards are be used for Texas SCHIP:

4.1.1. ~ Geographic area served by the Plan: Eligible children throughout the state will receive services

4.1.2. : Age: Children through the age of 18 years will be eligible

4.1.3. : Income: Children whose net family income is at or below 200% of the federal poverty level (FPL) will be eligible. Net family income will include offsets for such expenses as childcare, work-related expenses, and other deductions consistent with Medicaid standards

4.1.4. ~ Resources (including any standards relating to spend downs and disposition of resources): Family resources are not be taken into account in the determination of eligibility except in so for as they determine eligibility for Medicaid .

4.1.5. : Residency (so long as residency requirement is not based on length of time in state) : Children must be residents of Texas to be eligible for services

4.1.6. ~ Disability Status (so long as any standard relating to disability status does not restrict eligibility): Not applicable

4.1.7. : Access to or coverage under other health coverage: The application form asks for information on the insurance status of children making application. Children with existing health insurance are denied eligibility for Texas SCHIP.

4.1.8. : Duration of eligibility: Eligible children receive coverage for 12 continuous months

4.1.9. : Other standards (identify and describe): Immigration status: children who are legal residents but have not passed the five year bar are enrolled at the cost of the state.

As referenced in Section 4.3, the state does require the child's social

security number or proof of application for a social security number at the time of application.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ▪ These standards do not discriminate on the basis of diagnosis.

4.2.2. ▪ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ▪ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

The eligibility process for the Children's Health Insurance Program is easy to access, convenient for families and is identical to the Children's Medicaid eligibility process. A single application form is used for Medicaid & SCHIP. Families apply for children's health insurance by mail, by phone, through a web-assisted application or in person.

The application asks for the following information:

- Family's net income, including offsets such as child care, and the names of employers
- Age, names, social security numbers, and insurance status of children
- Composition of the family
- Resource information, if the family's income appears to make them eligible for Medicaid
- Immigration/Citizenship Status

Information from the application is entered into the SCHIP eligibility system. This entry may occur through several means: data entry by a telephone operator who receives the information through a phone call; data entry by a clerk at a central processing unit who reads the information from the application; or direct data entry via the internet to the extent feasible.

All applicants are screened for Medicaid eligibility before being deemed eligible for SCHIP. Any applications in which the family income and resources fall within Medicaid eligibility are routed to a Medicaid worker and data on that applicant are

transferred, electronically and in hard copy, to the Medicaid system, and Medicaid eligibility staff Data on those SCHIP applicants who are denied Medicaid by Medicaid eligibility staff are transmitted to the SCHIP system and those applicants are notified of their SCHIP eligibility and enrolled in SCHIP health plans.

Applicants applying via the Internet currently print out and sign applications, and mail them with necessary verifications to the central processing unit. Mail-in applications need to include the necessary verifications. In the case of phone applications, the data are printed out and sent to the family with a self-addressed envelope. The family returns the signed application with necessary verifications and enrollment fee if applicable after reviewing the application for accuracy.

Based on the eligibility information and the receipt of necessary verifications, the system makes a determination of eligibility and sends written notification to the family.

If a child is deemed SCHIP eligible the administrative services contractor ensures the family is provided information about their health plan choices and the child is enrolled in a health plan.

Twelve months of continuous eligibility begin on the day of the month following the month in which the enrollment fee is paid and the health plan selected in advance of the cutoff date. Two months before the end of the 12 months of continuous eligibility, families are sent a notice notifying them that they must renew the SCHIP coverage.

4.3.1 Describe the state? policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

? : Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

The SCHIP application asks whether applicant children are covered through existing health insurance. Children with health coverage are ineligible for SCHIP.

As described in Section 4.1 above, the application for Texas SCHIP and Medicaid, screens for Medicaid eligibility. Applications for children eligible

for Medicaid are processed by Medicaid workers and eligible children are enrolled in Medicaid. Data matches with Medicaid also are carried out to minimize the chances that children found eligible for Texas SCHIP are not already receiving health insurance.

Texas has two "state health benefits" plans: state employee health coverage under the state Employee Retirement System (ERS) and health coverage for active school district employees available through the Teachers Retirement System (TRS "Active Care"). State law treats these two groups differently, but children with access to either benefits plan are not eligible for SCHIP federal funding.

Children with access to TRS Active Care may be enrolled in Texas SCHIP program, but are identified and paid as state-funded members. Information about the availability of employer-based insurance and the employer name is obtained during the application process. Additionally, electronic data matching is performed with both the ERS and TRS systems to identify children with access to those benefits.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

As described in Section 4.4.2 above, Medicaid workers complete the enrollment of these children into the program. The state tracks applications of children who are deem Medicaid to determine whether eligible applicants choose to enroll.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**
Children determined ineligible for Medicaid are automatically enrolled in SCHIP based on electronic data sharing between the Medicaid eligibility agency and the SCHIP administrative services contractor.

4.4..4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ▪ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution. Labor analyses show that Texas has a low percentage of jobs in the manufacturing industries where dependent insurance coverage is highest. Employment in Texas is concentrated in retail, services

and small business, all of which have low rates of employee health benefits, particularly for lower-paying positions. Also, program design for Texas SCHIP , with such features as a commercially-based benefits package and cost-sharing provisions, are similar to private insurance and will thereby diminish the differences in consumers' minds between group health plans and SCHIP. Up to 150% FPL, crowd out is not anticipated to be a significant issue. The data are less clear at incomes between 150% and 200% FPL. Consequently, the program requires that applicants be uninsured for 90 days as a condition of eligibility. Provision is made to exempt families whose coverage has been discontinued through no fault of their own or who have discontinued coverage because the cost exceeded 10% of family income.

The application screens for whether the child has current insurance. If that is the case, eligibility for SCHIP is denied. If the application indicates that other insurance coverage was in effect during the previous 90 days, the applicant must indicate the date coverage ended, the reason, and the cost of the coverage. This information is used to determine if the children meet a good cause exception to the 90-day waiting period.

The State also monitors for substitution of coverage through SCHIP consumer surveys conducted by the External Quality Review Organization, evaluation of trends indicated by administrative data (e.g.: rates of "good cause" exceptions granted), and evaluation of statewide trends in insured/uninsured rates as indicated by the Current Population Survey (CPS) data.

4.4.4.2. ? Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ? Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ? If the state provides coverage under a premium assistance

program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4..5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Texas has three native American tribes:

- The Alabama Coushatta, located in Livingston, has 800 members;
- The Ysleta Del Sur, located in El Paso, has 1500 members;
- The Kickapoo, located in Eagle Pass, has 750 members.

Before the implementation of Texas SCHIP in these areas, the state contacted the tribes to determine how best to ensure the continued participation of tribal health clinics in the care of tribal members. Health plans are required to contract with or enter into special arrangement with tribal providers. These arrangements help ensure continuity of care for clients that choose to enroll in SCHIP .

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Outreach in the first two years of TexCare, which is the state's generic outreach campaign for Children's Medicaid and SCHIP, focused on a statewide media/marketing campaign focused on a call-to-action to families to call the TexCare hotline or send in a written application; direct application assistance by TexCare's contracted Community-Based Organizations' (CBO) outreach staff; and mass dissemination of information about the program. These strategies were appropriate for the "start-up" phase, as the challenge was to reach hundreds of thousands of unidentified families eligible for children's health insurance.

TexCare has always been designed to outreach on behalf of both Children's Medicaid and SCHIP. However, because SCHIP was a new and separately financed program that offered the first-ever opportunity of coverage to hundreds of thousands of families, much of the focus of state and local stakeholders has been on assuring the achievement of the ambitious SCHIP "start-up" goal. Now that SCHIP has been successfully launched, Texas is entering a new outreach phase that is dominated by the need to promote renewal and appropriate utilization of services. The Medicaid focus of the outreach effort has been sharpened with the implementation of SB 43 which is state legislation that was passed to simplify Children's Medicaid. This legislation benefits many families because it mandates an application and enrollment process for Children's Medicaid-eligible families as seamless, simple and transparent as that enjoyed by SCHIP-eligible families.

Texas' call-to-action outreach efforts that have been so effective in the first two years of the program have not stopped. But, these activities needed to be diversified and made more strategic as Texas' focus shifted to include the permanent incorporation of TexCare information in systems (e.g., schools) in the community and the perpetuation and appropriate utilization of existing coverage.

In all aspects of implementing TexCare, Texas has learned from the experience of other states. A review of that experience suggests that a broadening of Texas' strategy was appropriate. By diversifying beyond mass information dissemination and direct application assistance, the program will benefit from:

- increasing the efficiency of efforts to identify and target under-served populations;
- broadening and incorporating automatic information dissemination systems within organizations that have frequent contact with families;

- increasing the emphasis on all aspects of disease and disability prevention;
- communicating the fact that, through TexCare, families can afford to keep their children healthy and protected in the event of illness; and
- emphasizing family maintenance of health care coverage and appropriate utilization of services.

Other states' experience also shows that the program and the enrolled children benefit when efforts are made to keep enrolled children in health care coverage when their first period of eligibility expires.

Based on this experience, the state adopted the following goals for the next phase of outreach for TexCare:

- a long-term, integrated communication plan that includes coordinated community-based and statewide initiatives;
- an appropriate level of call-to-action through broad appeals and mass communications to reach eligible families;
- mass media messages and activities by TexCare contracted CBOs and health plans shifting primary emphasis from a call-to-action to the idea that through TexCare, families can afford to keep their children healthy and protected in the event of illness;
- increased emphasis on activities by TexCare CBOs and stakeholders to place TexCare information in the hands of families at times and places in which they are likely to be motivated by and interested in the information;
- activities by TexCare CBOs and stakeholders to work within organizations that have regular contact with families, i.e., emergency rooms, provider offices, pharmacies, schools, to set in place automatic and recurring "systems" to inform families and help them apply for health care coverage through TexCare; and
- continued activities to support enrollee families in successfully completing their annual renewal process, involving health plans, the administrative services contractor, and TexCare CBOs.
- the CHIP Car Safety Seat Pilot is a collaborative effort between the Health and Human Services Commission and the Texas Injury Prevention Network. The pilot is conducted in Hidalgo and Starr counties. The purpose of the pilot is to encourage families to complete their CHIP renewal and increase the appropriate use of child safety seats through distribution of and training in the proper use of safety seats. Families in the pilot area entering the renewal process are informed they may qualify to receive an age and weight appropriate car seat and safety training. Qualified families make an appointment to attend safety training and receive a car

seat when they complete the CHIP renewal process. The TIP Center utilizes the broadest possible community participation, including health plans, contracted CHIP community-based organizations, and local health departments. This event based plan involves going directly into the communities to distribute the car seats as well as inform and assist with renewal of children in CHIP. The pilot will run for 12 months.

- State-certified Community Health Workers, also known as promotora(s), will be utilized in target pilot areas to focus outreach to under-served populations. The program aims to bridge social, economic and cultural gaps to provide information about CHIP and preventive care to moderate and low-income families. Delivery of Community Health Worker training and services are designed to improve CHIP enrollment as well as promote preventive care on the CHIP program.

As the TexCare campaign to insure Texas children prepares to enter its third year, the continued success of the campaign will require the commitment of entire communities across the state of Texas.

Outreach now will become more strategic in nature as Texas seeks to work with entities in all sectors of the community to broaden and institutionalize the message to include the value of insurance, the importance of renewal and education on appropriate utilization of services.

Section 6. Coverage Requirements for Children?s Health Insurance (Section 2103)

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state?s Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ~ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ~ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. : State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. : HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. : Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

The benefits package for the Texas SCHIP provides comprehensive health coverage designed for children. Texas SCHIP benefits coverage is benchmark-equivalent to the HMO plan offered to state employees which happens to be the HMO in Texas with the largest insured commercial enrollment. See attached actuarial report. Please see section 6.2 for detailed information on benefits coverage, including amount, scope and duration of each service.

6.1.3. ~ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If ?existing comprehensive state-based coverage? is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for ?existing comprehensive state-based coverage.?

6.1.4. ~ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ? Coverage the same as Medicaid State plan

6.1.4.2. ? Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ? Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ? Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. 9 Coverage that is the same as defined by ? existing comprehensive state-based coverage?

6.1.4.6. ? Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ? Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. : Inpatient services **(Section 2110(a)(1))**
Covered, medically necessary inpatient services are unlimited and include, but are not limited to*:* Semi-private room and board (or private if medically necessary as certified by attending); general nursing care; ICU and services; patient meals and special diets; operating, recovery and other treatment rooms; anesthesia and administration (facility technical component); surgical dressings, trays, casts, splints, drugs, medications and biologicals; blood or blood products (if not provided free-of-charge to the patient) and their administration; X-rays, imaging and other radiological tests (facility technical component); laboratory and pathology services (facility technical component); machine diagnostic tests (EEGs, EKGs, etc); oxygen services and inhalation therapy; radiation and chemotherapy; access to TDH-designated Level III perinatal centers or hospitals meeting equivalent levels of care; hospital-provided physician services (facility technical component); and, in-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.

Exclusions and Limitations include: Infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system; personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury; experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community; treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court; custodial care; mechanical organ replacement devices, including, but not limited to artificial heart; private duty nursing services when performed on an inpatient basis; and, hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by the Health Plan.

The Health Plan may require prior authorization for: non-emergency care and following stabilization of an emergency condition; and, for in-network or out-of-network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section

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6.2.2. ▪ Outpatient services **(Section 2110(a)(2))**

Covered, medically necessary outpatient services are unlimited and include, but are not limited to, the following services provided in a hospital clinic, a clinic or health center, or an ambulatory health care setting: X-ray, imaging, and radiological tests (technical component); laboratory and pathology services (technical component); machine diagnostic tests; ambulatory surgical facility services; drugs, medications and biologicals; casts, splints, dressings; preventive health services; physical occupational and speech therapy; renal dialysis; respiratory services; radiation and chemotherapy; and blood or blood products (if not provided free-of-charge to the patient) and the administration of these products.

The Health Plan may require prior authorization and physician prescription for outpatient services.

6.2.3. ▪ Physician services **(Section 2110(a)(3))**

Covered, medically necessary physician and physician extender services are unlimited and include, but are not limited to, the following: American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations); physician office visits; inpatient and outpatient services; laboratory, x-rays, imaging and pathology services and professional interpretation; medications, biologicals and materials administered in the physician's office; allergy testing; (in/outpatient) surgical services, including surgeons for surgical procedures including appropriate follow-up care, administration of anesthesia by physician (other than surgeon) or CRNA, second surgical opinions, same-day surgery performed in a hospital without an over-night stay; invasive diagnostic procedures such as endoscopic examination; hospital-based physician services (including physician-performed technical and interpretative components); and, in-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.

Exclusions to physician services include: Infertility treatments, prostate and mammography screening; reproductive services other than prenatal care, labor and delivery, and care related to diseases, illnesses, or abnormalities related to the reproductive system; elective surgery to correct vision; gastric procedures for weight loss; cosmetic surgery/services solely for cosmetic purposes; cut-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section; services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan; acupuncture services, naturopathy and hypnotherapy; immunizations solely for foreign travel; routine foot care such as hygienic care; and diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)

The Health Plan may require prior authorization for specialty physician services.

6.2.4. ▪ Surgical services **(Section 2110(a)(4))**

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Covered, unlimited medically necessary surgical services, and limitations and exclusions to surgical services are described under inpatient, outpatient, and physician services.

6.2.5. : Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

Covered, unlimited medically necessary clinic services (including health center services) and other ambulatory health care services, and limitations and exclusions to these services are described under outpatient services.

6.2.6. : Prescription drugs **(Section 2110(a)(6))**
Open formulary based on the Texas Medicaid Program open formulary.
Covered, unlimited medically necessary prescription drugs include non-experimental, FDA-approved physician-prescribed drugs that are prescribed for the medical treatment of illness or injuries.

Exclusions include: contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care; and, medications for weight loss or gain.

The state may require prior authorization for selected drugs.

6.2.7. **9** Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. : Laboratory and radiological services **(Section 2110(a)(8))**
Covered, unlimited, medically necessary laboratory and radiological services, and limitations and exclusions to laboratory and radiological services are described under inpatient, outpatient, and physician services.

6.2.9. : Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**
Covered, unlimited prenatal care and care related to diseases, illnesses, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient, and physician services.

Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.

6.2.10. ▪ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**
Covered, medically necessary inpatient mental health services are furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated mental hospitals.

Inpatient mental health services are limited to a 45-day annual inpatient limit per 12 month period. Twenty-five (25) days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost. Twenty (20) of the inpatient days must be held in reserve for inpatient use only.

The Health Plan may require prior authorization for non-emergency services.

6.2.11. ▪ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**
Covered, medically necessary outpatient mental health services include, but are not limited to mental health services provided on an outpatient basis. Medication management visits do not count against the outpatient visit limit.

Outpatient mental health services are limited to: Sixty (60) days annual limit per 12 month period for rehabilitative day treatment; Sixty (60) outpatient visits annual limit per 12 month period for crisis stabilization, evaluation and treatment, including school, home-based and outpatient hospital services (includes but not limited to serious mental illness). Sixty (60) rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost.

The Health Plan may require prior authorization; however, outpatient mental health services do not require PCP referral.

6.2.12. ▪ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids,

dental devices, and adaptive devices) **(Section 2110(a)(12))**
Covered services includes durable medical equipment (equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness , injury or disability, and is appropriate for use in the home), and other medically-related or remedial devices that are medically necessary and necessary for one or more activities of daily living, and appropriate to assist in the treatment of a medical condition. These devises include, but not limited to: orthotic braces and orthotics; prosthetic devices such as artificial eyes, limbs and braces; contact lenses, when no other option is available to correct the diagnosed visual defect, such as keratoconus; hearing aides, prosthetic eyeglasses and contact lenses; other artificial aides including surgical implants.

Limitations include: $20,000 per 12-month period limit for DME, prosthetics, and devices. The health plan may require authorization for more than one pair of eyeglasses (the first pair does not count under the $20,000 cap) per 12 month period and or for contact lenses when medically necessary for the treatment of aphakia, or for head size or prescription changes. The Health Plan may reasonably limit the cost of the frames/lenses

Exclusions include: Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor; corrective orthopedic shoes; convenience items; diagnosis and treatment of flat feet; and, orthotics primarily used for athletic or recreational purposes.

The health plan may require prior authorization and physician prescription.

6.2.13. ▪ Disposable medical supplies **(Section 2110(a)(13))**
Covered benefits include diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.

Limitations and exclusions: Disposable medical supplies are included under the $20,000 12 month Durable Medical Equipment cap; however, diabetic supplies and equipment are exempted from this cap.

6.2.14. ▪ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

Covered, medically necessary home and community-based health care services include, but are not limited to: Speech, physical and occupational therapy; home infusion; respiratory therapy; skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.); home health aide services, when provided under the supervision of a R.N. and included as part of a plan of care during a period that skilled visits have been approved.

Limitations and exclusions to home and community-based health care services are: Excludes custodial care that assists a child with the activities of daily living and does not require the continuing attention of trained medical or paramedical personnel; excludes services intended to replace the child's caretaker or to provide relief for the caretaker; skilled nursing visits are provided on an intermittent level and are not intended to provide 24-hour skilled nursing services; services are for blocks of time and are not intended to replace 24-hour inpatient or skilled nursing facility services; excludes housekeeping services; excludes public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities; excludes services or supplies received from a nurse, which do not require the skill and training of a nurse.

The Health Plan may require prior authorization and physician prescription.

6.2.15. ▪ Nursing care services (See instructions) **(Section 2110(a)(15))**
Covered, unlimited medically necessary nursing care services include home visits for private duty nursing (R.N., L.V.N., block of time)

The Health Plan may require prior authorization and physician prescription.

6.2.16. ~ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ▪ Dental services **(Section 2110(a)(17))**
Preventive dental services covered once per year; includes exam, cleaning, x-rays, United dental sealants and fluoride.

Therapeutic dental services covered subject to a $300 annual cap per child, except for dental conditions related to an existing health care condition which are not subject to the cap.

Emergency dental services limited to fractured or dislocated jaw; traumatic damage to teeth; and removal of cysts.

Orthodontics limited to certain existing health care conditions; not for cosmetic purposes.

6.2.18. ▪ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**
Covered, medically necessary inpatient and residential substance abuse treatment services include detox and crisis stabilization, and 24-hour residential rehabilitation programs.

Limitations to inpatient and residential substance abuse treatment services are; 14 days annual limit for detox/crisis stabilization services; 60 days annual limit for 24-hour residential rehabilitation programs, or equivalent (30 days must be held in reserve; however, 30 days may be converted to 60 days partial hospitalization, 90 days intensive outpatient rehabilitation or 90 days of outpatient services); limited to a maximum of 3 episodes per lifetime.

The Health Plan may require prior authorization for nonemergency services.

6.2.19. ▪ Outpatient substance abuse treatment services **(Section 2110(a)(19))**
Medically necessary outpatient substance abuse treatment services include, but are not limited to prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.

Limitations to outpatient substance abuse treatment services are: intensive outpatient rehabilitation is covered for up to 12 weeks; outpatient services are covered for up to six months per episode; limited to a maximum of three outpatient episodes per plan lifetime; excludes aftercare for chemical dependency services such as, but not limited to, AA/NA, non-QCC support or education groups, and/or other services that primarily focus on relapse prevention to the member who completed treatment and/or their family members.

A set of services of less than one month in duration is not counted against the Member’s three-episode limit per plan lifetime, however, the maximum 24-hour residential rehabilitation program plan lifetime benefit must not exceed 180 days under any circumstance.

These services do not require a primary care provider referral; however, the health plan may require prior authorization

6.2.20. ▪ Case management services **(Section 2110(a)(20))**
Medically necessary case management services above and beyond those normally provided to all members are covered for Children with Complex Special Health Care Needs. These covered services include outreach, informing, intensive case management, care coordination and community referral.
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6.2.21. ▪ Care coordination services **(Section 2110(a)(21))**

6.2.22. ▪ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**
Covered, medically necessary habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to
physical, occupational and speech therapy and developmental assessment.

Reimbursement for school-based services are not covered except for therapy services ordered by the PCP.

The Health Plan may require authorization and physician prescription.

6.2.23. ▪ Hospice care **(Section 2110(a)(23))**
Covered, medically necessary hospice services include, but are not limited to palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death. Treatment for unrelated conditions is unaffected

Limitations include: Services apply only to the hospice diagnosis; limited to a maximum of up to 120 days with a 6 month life expectancy; and, patients electing hospice services must waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime.

The Health Plan may require authorization and physician prescription.

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6.2.24. ▪ Any other medical, diagnostic, screening, preventive, restorative,

remedial, therapeutic, or rehabilitative services. (See instructions)
(Section 2110(a)(24))

Skilled Nursing Facility (including Rehabilitation Hospital) Services
Covered, medically necessary skilled nursing facility and rehabilitation hospital services include, but are not limited to: Semi-private room and board; regular nursing services; rehabilitation services; and medical supplies and use of appliances and equipment furnished by the facility. Coverage is limited to 60 days per 12-month period. Private duty nurses, television and custodial care are excluded. The Health Plan may require authorization and physician prescription.

Emergency Services including Emergency Hospitals and Physician
Covered, medically necessary covered services include:
emergency services based on prudent lay person definition of emergency health condition; hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers; medical screening examination; stabilization services; access to designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services. The Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery; however, the health plan may require authorization for post-stabilization services.

Vision Services
Covered, medically necessary services include: one examination of the eyes to determine the need for and prescription for corrective lenses per 12 month period, without Health Plan authorization; one pair of nonprosthetic eyewear per 12 month period. The health plan may reasonably limit the cost of the frames/lenses. Vision training and vision therapy are excluded

Transplant Services
Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses are covered, if medically necessary. Donor non-medical expenses are not covered. The Health Plan may require prior authorization.

Smoking Cessation Programs
A Health Plan approved smoking cessation program is covered up to a $100 limit per 12-month period. The Health Plan may require prior authorization.

Chiropractic Services
Medically necessary services are limited to spinal subluxation. Chiropractic services do not require physician prescription. Limited to twelve visits per twelve-month period (regardless of number of services or modalities provided in one visit).

6.2.25. ~ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. : Medical transportation **(Section 2110(a)(26))**
Emergency ground, air or water transportation is a covered services.

6.2.27. ~ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ~ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. : The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ~ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ~ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through

such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28.** **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ~ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state?s Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (**2102(a)(7)(A)) (42CFR 457.495(a))**

The state has used numerous methods to assure that SCHIP beneficiaries receive quality services that are appropriate to their needs. These methods include the following:

- Requirement that health plans submit patient-level encounter data to the SCHIP quality assurance contractor. The data is the analyzed using HEDIS and other benchmarks to assess the provision of well-baby, well-child and immunization services.

- Assess health plan delivery of child health services through comprehensive surveys of the enrolled SCHIP population.

- Requirement that HMOs and EPOs develop and maintain quality assurance and quality improvement programs.

- Verification that HMOs and EPOs have sufficient network providers and procedures to ensure children have access to routine, urgent, and emergency services; telephone appointments; and advice and member service lines.

- Restrictions on physician incentive plans.

- Requirement that HMOs and EPOs provide training to providers on a number of topics including the special needs of SCHIP Phase II clients.

- Requirement that HMOs and EPOs have health education and wellness promotion programs.

- Requirement that HMOs and EPOs maintain a toll-free member hotline 24 hours a day, seven days a week for obtaining assistance in accessing services.

- Requirement that HMOs and EPOs develop, implement and maintain a member complaint system.

- Requirement that HMOs and EPOs send notice to SCHIP beneficiaries on the

HMO's appeals process for services that are denied, delayed, reduced or terminated.

- Access to a grievance process to appeal an HMO or EPO action.

In addition to internal monitoring processes, an external quality monitor is used to evaluate quality assurance activities described above for the HMO and EPO models.

To ensure children receive proper well-baby and well-child care and immunizations, HMO and any EPO providers are required to do the following:

- Provide children with well-baby and well-child care and immunizations according to the American Academy of Pediatrics or Texas Department of Health periodicity schedule for children. Provide well-child care and immunizations to all children except when the family refuses services after being provided accurate and complete information about services.

- Ensure that families are provided information and education materials about well-child care and immunizations, especially the importance of well-child checkups**,** and about how and when to obtain the services.

- Provide training to network providers and provider staff about well-child care and immunizations.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ▪ Quality standards
Health Plans are encouraged to follow QISMC guidelines and other standards established by the state in the development and maintenance of their Quality Improvement Programs.

7.1.2. ▪ Performance measurement
.Texas is using a variety of performance measures to assess program quality, including pediatric HEDIS measures, ambulatory care sensitive conditions, case-mix adjusted actual versus expected experience rankings, and consumer survey results (including results from the Consumer Assessment of Health Plans Study (CAHPS)).

7.1.3. ▪ Information strategies
The Quality Assurance contractor produces reports for analysis which focus on the review and assessment of quality of care given by SCHIP health plans,

detection of over and under-utilization, and other user-defined reporting criteria and standards.

7.1.4. ▪ Quality improvement strategies
The state requires all SCHIP Health Plans to develop and maintain a Quality Improvement Program (QIP) system which complies with federal regulations relating to Quality Assurance systems,, and state insurance department regulations. Each Health Plan QIP must be approved by the state. Health Plans must conduct focused health studies in areas established by the state. All aspects of the health plans QIP will be monitored by the state. The state will also perform ongoing medical record reviews, and retrospective medical record reviews for health plans.

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**
As a means of measuring accessibility**,** the state has established standard ratios of full-time equivalent PCPs to SCHIP beneficiaries and full-time board certified/board eligible pediatricians to SCHIP beneficiaries.

Network managers are required to ensure that primary care providers (PCP) are located no more than 30 miles from any member, unless approved by the state. No member is required to travel in excess of 75 miles to secure initial contact with referral specialists; special hospitals, psychiatric hospitals; diagnostic and therapeutic services; and single service health care physicians or providers except when approved by the state. Networks must include pediatricians and physicians with pediatric experience that is adequate to provide eligible children and adolescents with the full scope of benefits.

Network managers are required to demonstrate their ability to monitor network capacity and member access to needed services throughout the geographic service area in order to maintain the adequacy of the network. Managers need to maintain systems for monitoring patient load so that they can effectively plan for future needs and recruit providers as necessary to assure adequate access to primary care and specialty care. Health plan are also required to routinely monitor and ensure the after-hours availability and accessibility of PCPs.

The state requires that networks provide access to urgent care within 24 hours of request and routine care within 2 weeks of request. The state also requires that networks provide medically necessary emergency services 24 hours a day, seven days a week, either by access to the PCP or after-hours coverage through the Health Plan’s network facilities, or through reimbursement of out—of-network providers.

Networks are required to maintain a toll-free member hotline 24 hours a day, seven days a week for obtaining assistance in accessing services.

The state tracks network utilization controls and will monitor inpatient admissions, emergency room use, ancillary, and out-of area services for SCHIP network clients.

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**
SEE 7.1

7.2.2 Access to covered services, including emergency services as defined in 42 CFR ?457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**
SEE 7.2

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**
The state monitors the status of children with special health care needs through quarterly reviews of encounter data and periodic surveys of the SCHIP families. When deficiencies are identified, among particular plans, corrective action plans are implemented.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

The state assures decisions related to the prior authorization of health services are completed in accordance with state law by reviewing quarterly member and provider complaint reports, conducting spot audits and completing, with the state's EQRO, a periodic Quality of Care Survey of members.

SCHIP health plans are subject to state commercial insurance statutes and regulations regarding utilization review, which contain requirements as stringent as federal provisions.

Section 8. Cost Sharing and Payment (Section 2103(e))

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state**?**s Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. : YES

8.1.2. ~ NO**, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: See costing sharing table .
.

8.2.2. Deductibles: See costing sharing table

8.2.3. Coinsurance or co-payments: See costing sharing table

At or below 100% of FPL	**Charge**
Enrollment Fee	$0
Monthly Premium	$0
Office Visit	$0
ER	$3
Generic Drug	$0
Brand Drug	$3
Co-pay Cap	$100
Deductible, non-institutional	$0
Deductible, institutional	$0
Facility Co-pay, Inpatient	$0
Facility Co-pay, Outpatient	$0
101% to 150% of FPL	**Charge**
Enrollment Fee	$15 per yr./per family
Monthly Premium	$0
Office Visit	$2
ER	$5
Generic Drug	$0
Brand Drug	$5
Co-pay Cap	$100
Deductible, non-institutional	$0
Deductible, institutional	$0

Facility Co-pay, Inpatient (per admission	$25
Facility Co-pay, Outpatient	$0
151% to 185% of FPL	**Charge**
Enrollment Fee	$15 (1st month's premium)
Monthly Premium	$15 per mo./per family
Office Visit	$5
ER	$50
Generic Drug	$5
Brand Drug	$20
Co-pay Cap	5% (of family's net income)
Deductible, non-institutional	$0
Deductible, institutional	$0
Facility Co-pay, Inpatient (per admission	$50
Facility Co-pay, Outpatient	$0
186% to 200% of FPL	**Charge**
Enrollment Fee	$18 (1st month's premium)
Monthly Premium	$18 per mo./per family
Office Visit	$10
ER	$50
Generic Drug	$5
Brand Drug	$20
Co-pay Cap	5% (of family's net income)
Deductible, non-institutional	$0
Deductible, institutional	$0
Facility Co-pay, Inpatient (per admission	$100
Facility Co-pay, Outpatient	$0

8.2.4. Other: See cost sharing table for enrollment fee amounts.

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**
Outreach materials reference nominal cost sharing requirements. Applications for Texas SCHIP include information about the enrollment fee and stipulate that enrollment in the program is contingent on payment of the enrollment fee at the time of application. The administrative services contractor provides information to SCHIP families about the required enrollment fee and co-payments for services. Health plans also include information on co-payments in member handbooks sent to SCHIP beneficiaries once enrolled.

8.4. The state assures that it has made the following findings with respect to the cost sharing

in its plan: **(Section 2103(e))**

8.4.1. ▪ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ▪ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ▪ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child?s eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

Families receive information during the enrollment process on how to track and report their cost sharing expenditures. Texas uses a cap lower than 5% for families below 150% of the FPL (see section 8.2.3).

When a family is near their cap on out of pocket cost sharing, they submit a form to the SCHIP administrative services contractor, which in turn, notifies the member's HMO. The HMO sends the member a new membership card that indicates no cost sharing is required through the end of that member's enrollment period.

In addition to seeing the member's card (which would indicate no cost sharing required if cap has been reached), providers can also access a toll-free line operated by the SCHIP administrative services contractor that provides eligibility information.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

American Indian applicants identify themselves on the application. The administrative services contractor uses a special identifying code for American Indians. This code ensures that American Indians are not charged a premium or enrollment fee. The American Indian identifier is transmitted electronically to the health plans. Under the state's contract, the health plans are prohibited form assessing co-payments for American Indians. Heath plan Member ID cards for American Indians mush show that

they owe no co-payments for services. The health plan also is contractually required to educate providers about the cost sharing waiver for American Indians.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

Enrollees who do not pay the monthly premium cost sharing amounts receive two late notices. If payment is not received after the second notice, the enrollee(s) will be disenrolled as of the beginning of the following month. Enrollees may reenroll after a 90-day waiting period and full payment of all past due cost sharing.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, co-payments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- The disenrollment process affords the enrollee an opportunity to show that the enrollee?s family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**
- In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child?s cost-sharing category as appropriate. **(42CFR 457.570(b))**
- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. No cost-sharing (including premiums, deductibles, co-pays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (Previously 8.4.5)

8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of

June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ~ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)** NOT COVERED

8.8.6. ~ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)** NOT COVERED

Section 9. Strategic Objectives and Performance Goals and Plan Administration **(Section 2107)**

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Strategic Objective 1: Provide Increased Access to Health Care Coverage for the New SCHIP-Enrolled Texas Children in Families with Income at or below 200% of Poverty.

Strategic Objective 2: Provide Increased Preventive and Primary Health Care Services to new SCHIP-Enrolled Texas Children.

Strategic Objective 3: Provide Improved Health Outcomes for New SCHIP-Enrolled Texas Children through Appropriate Utilization of Health Care Resources.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

Strategic Objective 1: Provide Increased Access to Health Care Coverage for the New SCHIP-Enrolled Texas Children in Families with Income at or below 200% of Poverty.

Performance Goal A: Compare annual data of the number and percent of children enrolled in SCHIP to the estimated number of potentially SCHIP eligible children in the state.

Performance Goal B: Track participation by county, age, and racial/ethnic groups.

Strategic Objective 2: Provide Increased Preventive and Primary Health Care Services to new SCHIP-Enrolled Texas Children.

Performance Goal A: Track number and percentage of SCHIP-coverage children with completed immunizations at end of middle school (approximately 12-14 years of age).

Performance Goal B: Track number and percentage of SCHIP-coverage children receiving well child checkups by county, age, and racial/ethnic groups.

Strategic Objective 3: Provide Improved Health Outcomes for New SCHIP-Enrolled Texas Children through Appropriate Utilization of Health Care Resources.

Performance Goal A: Track number and percentage of SCHIP-coverage children receiving well child checkups by county, age, and racial/ethnic groups.

Performance Goal B: Track number and percentage of SCHIP-coverage children receiving emergency services by county and age.

Performance Goal C: Track number and percentage of SCHIP-coverage children having hospital discharges by county and age.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state?s performance, taking into account suggested performance indicators as specified below or other indicators the state develops: **(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))**

The strategic objectives and performance goals of the Title XXI SCHIP program have been initiated for the first biennium based on the principal desire of the state to plan and implement a successful SCHIP program in Texas. In order to be successful, the program design includes significant attention to outreach, eligibility determination, enrollment, and the participation of providers and children.

The state developed three strategic objectives to measure access, service provision, and health resources utilization as a means of evaluating the health status of children in the SCHIP program. Data have been obtained from managed care plans and surveys. Health plan patient-level encounter data have been analyzed using case-mix adjustment process, including the Chronic Disability Payment System (CDPS), and Ambulatory Care Groups (ACGs) frameworks. In addition, the state has used encounter data to assess health plan performance on child and adolescent HEDIS measures. The state has also completed three enrollee surveys, including a survey of New Enrollees, Disenrollees, and a Consumer Assessment of Health Plans Study (CAHPS) survey of each health plan by service area.

Knowing that the state, plans, providers, and children have been engaged in a program which is new to all participants, the state has provided technical assistance to its contractors to improve the reporting and systems support required to perform these evaluation functions. The technical assistance has been concentrated in such a way as to logically increase the information obtained from the data being reported over time. Thus, during the first year, the state concentrated on the first strategic objective relating to increasing access of children newly enrolled in health care coverage. During the second year, the state focused on the achievement of the second strategic objective related to increasing the process (i.e. number of preventive and primary health care services) of children newly enrolled in health care coverage. In the third year of the program, the state will continue the necessary reporting to track these two strategic objectives, but will also concentrate on the third strategic objective of comparing the utilization of primary and preventive care services to the utilization of hospital and emergency services.

It is anticipated that these strategic objectives and performance goals may be supplemented in the future, especially in light of CMS's performance measures initiative and protocols regarding quality assurance. Methodologies, such as well child focused studies undertaken by the plans and surveys of members, providers, and plans undertaken by the external quality review organization(EQRO), may be considered by the state, after the new EQRO begins work for SCHIP in May 2003..

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ~ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. : The reduction in the percentage of uninsured children.

9.3.3. ~ The increase in the percentage of children with a usual source of care.

9.3.4. ~ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. : HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ~ Other child appropriate measurement set. List or describe the set used.

9.3.7. ~ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. : Immunizations

9.3.7.2. : Well child care

9.3.7.3. ▪ Adolescent well visits

9.3.7.4. ~ Satisfaction with care

9.3.7.5. ~ Mental health

9.3.7.6. ~ Dental care

9.3.7.7. ▪ Other, please list:
Additional measures in relation to which health plans data are to be collected are being negotiated with the Texas Health Care Information Council (THCIC).

9.3.8. ~ Performance measures for special targeted populations.

9.4. ▪ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ▪ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state?s plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**
Texas will develop the necessary data sources and baselines with which to assess and evaluate program performance consistent with Title XXI requirements and the requirements of day-to-day program management. HHSC will dedicate staff or contracted resources to review program performance and develop strategies for improvement

9.6. ▪ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ▪ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ▪ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ▪ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ▪ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ▪ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**
The state has actively sought the involvement of the public in the development of the Texas SCHIP Phase II program through numerous avenues. The Lieutenant Governor established the Senate Interim Committee on Children's Health Insurance in March 1998, which heard extensive testimony during the summer from the public on the policy options and recommendations for SCHIP. The Texas House Committee on Appropriations and the Texas House Committee on Public Health also participated in joint public hearings on SCHIP with the Senate Interim Committee. Hearings were widely publicized through the Texas Register, media advisories, Internet web sites, and targeted mailings to advocacy groups. State agency representatives have met on a regular basis with legislative staff to gain legislative input on the development of draft proposals.

In addition to legislative public hearings, the Health and Human Services Commission, in collaboration with the Texas Department of Health, the Texas Department of Human Services, and the Texas Department of Mental Health and Mental Retardation held 10 public hearings around the state throughout the fall of 1998 and early in 1999. The state made a concerted effort to attract families, providers, health officials, advocates, community-based organizations, and other community representatives to these hearings, specifically by working with state and local SCHIP Coalitions representing a broad range of consumer and provider interests. Public hearings were held in late afternoon – early evening to better allow family members to attend. The state also hosted local discussions at each of the public hearing sites to establish community linkages and gain community input on local outreach strategies and other topics in a more informal setting. Local advisory groups will be used to provide ongoing direction and input on outreach strategies for Texas SCHIP .

A number of advocacy groups in Texas formed the SCHIP Coalition in Spring 1998. State representatives have met regularly with the SCHIP Coalition, making presentations on various aspects of the program design and seeking feedback throughout the development process. The state plans to continue using the SCHIP Coalition to provide input and guidance on program components as Texas SCHIP is implemented. The state has also met with the Disability Policy Consortium, which represents statewide disability advocacy groups, to discuss developments in Texas SCHIP.

Throughout the past year, state representatives have met with state provider organizations, such as the Texas Medical Association and the Texas Hospital Association. State staff have presented at numerous provider conferences and meetings. Continued involvement of these organizations will be essential in the operation of

Texas SCHIP .

Public involvement in implementation of Texas SCHIP will continue to be ensured through state agencies' rule-making processes and through public participation in outreach efforts. In addition, regional advisory committees with broad representation across provider and consumer groups and including parents of SCHIP enrollees have been formed to provide advice on program policy, management, and outreach.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR ?457.125. **(Section 2107(c)) (42CFR 457.120(c))**

HHSC requires health plans to seek participation in its provider network from the tribal health clinics.

American Indian and Alaska Native children are exempt from cost sharing.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in ?457.65(b) through (d).

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

? Planned use of funds, including --
- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

? Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

SCHIP Budget Plan Template

	Federal Fiscal Year 2003 Costs	foot notes
Enhanced FMAP rate	**0.2801**	
Benefit Costs		
Insurance payments		
Managed care		
per member/per month rate @ # of eligibles	453,043,917	1
Dental	60,041,306	2

Fee for Service		
Prescription Drugs	82,561,857	
Vaccines	2,067,758	
Total Benefit Costs	**597,714,838**	
(Offsetting beneficiary cost sharing payments)	15,821,869	
Net Benefit Costs	**581,892,970**	
Administration Costs		
Personnel	5,244,772	3
General administration	3,986,664	4
Contractors/Brokers (e.g., enrollment contractors)	30,235,359	5
Claims Processing		
Outreach/marketing costs	7,862,640	6
Other		
Car Seat Pilot	1,399,822	7
Community Health Worker Pilot	66,940	8
Quality Assurance	750,000	
Actuary	127,500	
Total Administration Costs	**49,673,697**	
10% Administrative Cost Ceiling	64,654,774	
Federal Share (multiplied by enh-FMAP rate)*	454,664,843	
State Share*	176,901,823	
TOTAL PROGRAM COSTS	**631,566,666**	
***State Share includes $410,840 in Approved Bona Fide Donations for Car Seat and Community**		

Notes: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.
Based on cost data from Nov. LAR updatedate from Nov. LAR update
Uses September 2002 Caseload

FFY2003 has 11 payments and FFY2002 has 13 pymts, since Oct 2002 payment was prepaid in FFY2002

1 avg rate $82.85 MPM 497,113

2 avg rate $10.98 MPM 497,113

3 salaries HHSC $3,674,007 + DHS $1,570,765 = $5,244,772

4 admin non salaries HHSC $3,433,782 + DHS $552,882 = $3,986,664

5 B&D contract

6 outreach includes CBOs and Sheri Mathews

7 total CMS approved funding for FY ‘02 and FY ‘03 is $2,000,000

8 total amount of the Rockwell Fund, Inc. is $25,000

Assumptions:

Program Expenditures represent payments to health providers for providing health care services to CHIP enrollees. These expenditure estimates are based upon the yearly mean average of enrollees and the average cost per enrollee per month. Administrative Expenditures represent the cost of eligibility determination and enrollment services, outreach, quality assurance and agency administrative costs.

The funding source for the state share for state fiscal year 2002 and beyond includes appropriated state funds and may include other public funds certified or transferred from public agencies consistent with applicable federal law and regulations.

Funding Sources
The funding source for the state share for state fiscal years 2002 and beyond includes appropriated state funds and may include other public funds certified or transferred from public agencies consistent with applicable federal law and regulations.

Sources of state share for state fiscal year 2002 and beyond also include bona-fide donations consistent with Section 2107(e)(1)(C) of the Social Security Act, Section 1903(w) of the Act, and other applicable federal law and regulations. The following provides background on the donors, donor sources of revenue and donor funding flow for the two projects that involve bona-fide donations: 1) Car Safety Seat Pilot (submitted on November 25th and effective June 1, 2002) and 2) Community Health Workers Project (approved in correlation with the compliance SPA amendment).

Donor(s)

Car Safety Seat Pilot:
The car safety seat pilot is funded by the Rio Grande Valley Safe Communities Coalition (RGVSC). This coalition includes the following organizations: TRW Foundation (Thompson, Ramo & Wooldrige), Mattell Foundation, Ronald McDonald Charities, Coca-cola Foundation, CP&L Energy (changed name to AEI), TXU Energy, South Texas Ford Dealers Association, South Texas GM Dealers Association, South Texas Dodge Dealers Association, Williamson Construction, Whirlpool Industries, H.E.B. Stores, Inter National Bank, Texas State Bank. The total CMS approved funding for FY02 and FY03 is $2,000.000.

Community Health Workers Project
The donor for the community health worker project is the Rockwell Fund, Inc. James M. Rockwell established the Rockwell Fund as a charitable trust in 1931. It was incorporated in Houston in 1949 to provide financial support for charitable, religious, civic and medical activities. A second foundation, Rockwell Brothers Endowment, was incorporated in 1960 and later merged with the Rockwell Fund. The total amount of the donation is $25,000.

Donor Sources of Revenue

Car Safety Seat Pilot
The RGVSC does not receive any of its revenues from health care entities (supporting documentation is on file at CMS).

Community Health Workers Project
According to the Statement of Revenue and Expenses for the month ended October 31, 2002 and the Ten Months Ended October 31, 2002 and 2001 (supporting documentation is on file at CMS), it is assured that the Rockwell Fund, Inc. receives no annual revenues from health care providers and does not provide medical or administrative related (including outreach) services under SCHIP.

Funding Flow

Car Safety Seat Pilot
Donations will flow from the donor entity (Rio Grande Valley Safe Communities Coalition) to the Health and Human Services Commission, which in turn will reflect the amount of those donations in its federal funds claims.

Community Health Workers Project
Donation will flow from the donor entity (The Rockwell Fund, Inc.) to the Health and Human Services Commission, which in turn will reflect the amount of those donations in its federal funds claims.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. ▪ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ▪ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ▪ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

? **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state**?**s Medicaid plan**, and continue to Section 12.

11.1 : The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. : 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. : Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. : Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. : Section 1128A (relating to civil monetary penalties)
- 11.2.5. : Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. : Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

? **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state? s Medicaid plan.**

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR ?457.1120.

Both the TexCare review and the HHSC review processes described below are impartial reviews:

Eligibility and Enrollment Matters Review and Reconsideration Process

1) An applicant or member may request a review of an initial adverse determination made by the administrative contractor concerning the following:
    a) denial of eligibility;
    b) failure to make a timely determination of eligibility;
    c) enrollment or disenrollment, including disenrollment due to failure to meet cost-sharing obligation;
    d) an increase in a member's cost-sharing obligation; and
    e) re-assignment to a different health plan.
2) Matters Not Subject to Review. The state is not required to provide an opportunity for review and reconsideration if the sole purpose for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or members or a group of applicants or members without regard to their individual circumstances.

Reconsideration by the Health and Human Services Commission

If TexCare's decision following its review is adverse to the applicant or member, he or she may request an additional reconsideration by the Health and Human Services Commission.

Notice of Adverse Determinations

TexCare must provide the applicant or member written notice of any adverse eligibility

or enrollment determination. The notice must include:

1) the action or determination and the reasons supporting it;

2) the individual's right to request review and reconsideration of the action or determination;

3) the process for initiating a review or reconsideration;

4) the time frame that applies to the review or reconsideration; and

5) the circumstances under which enrollment, if applicable, may continue pending review and reconsideration.

Requesting a Review

The applicant or member must submit a written request for review.

Conduct of the Review

Applicants and members have a right to:

1) represent themselves or have representatives of their choosing participate in the review;

2) timely review their files and other applicable information relevant to the review; and

3) participate fully in the review, whether the appeal is conducted in person, in writing, or by telephone.

Disposition of the Review

TexCare must complete its decision on the review in a timely manner and furnish a copy of the decision to the applicant or member. The review decision must:

1) state whether the initial adverse action or determination was upheld or reversed and the reasons why; and

2) explain the individual's right to request a second reconsideration by the Health and Human Services Commission or its designee, of the initial adverse action or determination, and include instructions on requesting reconsideration.

Reconsideration by the Health and Human Services Commission

1) An applicant or member must request reconsideration by HHSC in writing.

2) HHSC must complete its reconsideration of its final decision in a timely manner based upon receipt of the written request for reconsideration by HHSC.

3) The reconsideration decision must include the reasons for the decision.

Continuation of Enrollment Pending Disposition of Review and Reconsideration

TexCare will grant continuation of enrollment pending review and reconsideration of a disrenrollment determination, including disenrollment for failure to pay cost sharing.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR ?457.1120.

HHSC requires health insurance insurers to comply with State-specific grievance and appeal requirements currently in effect in the State.

Health Services Matters are:

1) delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and

2) failure to approve, furnish, or provide payment for health services in a timely manner.

Complaints Concerning Health Services Matters Pursuant to Insurance Code

A member, or a person acting on the member's behalf, or the member's physician or health care provider may file a complaint about an adverse determination made by a health plan provider pursuant to the provisions of Chapter 20A and article 21.58A, Insurance Code. Such a complaint may lead to review by an independent review organization formed pursuant to article 21.58C, Insurance Code.

Expedited Process for Complaints Concerning Health Services Matters

Investigation and resolution of complaints concerning health services matters must be concluded in accordance with the medical needs of the patient.

Disenrollment Notification Process

Within ten calendar days of determining a member should be disenrolled, TexCare sends the applicant a disenrollment notification letter explaining:

(1) the reason for disenrollment;
(2) the effective date of the disenrollment;
(3) the member's right to request review by the TexCare of the decision and the time frames

for the review process;
(4) the member's right to request impartial reconsideration by HHSC, if he or she disagrees with TexCare's review decision, and the time frames for the reconsideration process; and
(5) how to request review and reconsideration.

Notification of Eligibility Denials

Within 5 business days of determining an eligibility denial, TexCare sends the applicant an eligibility denial notification letter explaining:

(1) the reason for the denial;
(2) the member's right to request review by TexCare of the decision and the time frames for the review process;
(3) the member's right to request impartial reconsideration by HHSC, if he or she disagrees with TexCare's review decision, and the time frames for the reconsideration process; and
how to request review and reconsideration

Timelines for Reviews

(1) families have 30 working days from date of notification letter to submit an appeal concerning TexCare's decision to deny eligibility or disenroll.
(2) TexCare has 10 working days after receiving appeal (in writing) to respond with a notice that the decision has been upheld or has been reversed.
(3) families have 15 working from date of response letter to submit written request for additional HHSC review.
(4) within 5 working days of date of receipt, TexCare notifies HHSC of request for additional HHSC review.
(5) HHSC has 15 working days to respond to family and notify TexCare of HHSC decision

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR ?457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

ACTUARIAL REPORT

Rudd and Wisdom, Inc.

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May 9, 1999

Mr. Jason Cooke
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

Re: Actuarial Certification for the Children's Health Insurance Program

Dear Jason:

Attached is the actuarial certification for the Children's Health Insurance Program's (CHIP) benefit package required by Section 2103 of the Balanced Budget Act (BBA) of 1997. Based on the results of the analysis described in the attachment and our understanding of Section 2103, we believe that the benefits offered under the CHIP benefit package satisfy the BBA requirements for (i) inclusion of basic services, (ii) substantial actuarial value for additional services and (iii) benchmark-equivalent coverage.

Please let me know if you have any questions or need additional information.

Sincerely,

David G. Wilkes, FSA, MAAA

DGW:nlg

Enclosure

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TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Effective Date: 63 Approval Date:

State Child Health Plan
Actuarial Analysis of Benefit Package

At the request of the Texas Health and Human Services Commission, we have analyzed the Children's Health Insurance Program (CHIP) benefit package and its compliance with Section 2103 of the Balanced Budget Act (BBA) of 1997. In this report we describe the methodology and assumptions used and summarize the results of our analysis.

Section 2103(c)(4) of the BBA requires that the actuarial analysis be prepared:

(A) by an individual who is a member of the American Academy of Actuaries;
(B) using generally accepted actuarial principles and methodologies;
(C) using a standardized set of utilization and price factors;
(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;
(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);
(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

We certify that these requirements have been met based on our understanding of the Act. Additional detail regarding the methodologies and assumptions used in the analysis are contained herein.

Benchmark Benefit Packages

Together with the CHIP Policy Team, we selected benchmark benefit packages in accordance with the requirements of Section 2103(b) of the BBA.

- The Federal Employee Health Benefits Plan's standard Blue Cross/Blue Shield preferred provider option referred to herein as FEHBP benefits.
- The Uniform Group Insurance Program (UGIP) HealthSelect point-of-service managed care plan provided to employees and retirees of the State of Texas.
- The UGIP HMO benefit plan provided to employees and retirees of the State of Texas.

While FEHPB benefits and UGIP HealthSelect were essentially defined in the BBA, selection of an HMO benefit package as a benchmark was less clear-cut. The Health Care Financing Administration (HCFA) responded to various questions concerning CHIP in a series of documents released beginning in September, 1997. In a release dated October 3, 1997, HCFA indicated that the HMO benchmark coverage is the "particular insurance product (i.e., benefit package) with the largest number of enrolled commercial, non-

Medicaid covered lives offered by an HMO, rather than simply the HMO with the largest total commercial enrollment within all benefit packages offered by the HMO." The UGIP HMO benefit package, though presently provided by 17 different HMOs, is a uniform benefit package covering some 260,000 participants. It is the largest or one of the largest plans for each of the HMOs participating in the UGIP. As a result, we concluded that the UGIP plan would be the HMO benefit package with the largest enrollment in the state.

Uninsured Populations Evaluated for Coverage

In evaluating the relative cost of the CHIP benefit package and the benchmark plans, we considered the anticipated average cost of coverage for the four populations of uninsured children defined below.

Population	Age	Federal Poverty Level (FPL)
A	6-18	101-133%
B	1-5	134-150%
	6-18	101-150%
C	1-5	134-185%
	6-18	101-185%
D	1-5	134-185%
	6	101-185%
	7-18	101-150%

Attached Exhibit A presents the number of children by age and Federal Poverty Level which we assumed in our analysis.

Contractual Arrangements

For purposes of developing the estimated actuarial values included herein, we have assumed that benefits will be delivered through either (a) a single statewide plan or (b), at most, a limited number of regional plans that would be either (i) self-funded and/or self-administered by the state or (ii) established with private carriers subject to insured contracts negotiated and managed by the state. The actuarial values presented herein would not necessarily be applicable to the same benefits provided under independent employer plans for which an eligible child might quality as a result of a parent's employment.

CHIP Benefit Package

Attached Exhibit B presents the CHIP benefit package which we evaluated. Covered services include those required by Section 2103(a)(2)(A) of the BBA as Basic Services - inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services and well-baby and well-child care, including age-appropriate immunizations.

Section 2103(a)(2)(C) of the BBA requires that if the benchmark plan includes coverage for (i) prescription drugs, (ii) mental health services, (iii) vision services and/or (iv) hearing services, then the CHIP benefit plan must include coverage for those services and the actuarial value of the CHIP benefit must be at least 75% of that for the benchmark plan. We have determined that the actuarial value of the CHIP coverage for each of these services is at least 75% of the actuarial value of the service for each of the benchmark plans.

Estimated Actuarial Values of the CHIP and Benchmark Benefit Packages

The determination of actuarial values for the CHIP and benchmark benefit packages requires actuarial assumptions concerning the utilization and price of each of the benefits included in the packages for each group of children described above. The assumptions as to price and utilization of health care services were developed based on data available from the Medicaid fee-for-service program appropriately adjusted for the age distribution of the populations under consideration. In accordance with the requirements of the BBA, we have determined the actuarial values without taking into account any differences in value that could arise from the particular delivery system (HMO, indemnity, etc.) applicable to a given benchmark plan. In this regard, we have developed estimated actuarial values assuming that benefits would be delivered through and administered under a traditional fee-for-service arrangement like that presently used for the Medicaid fee-for-service program.

The estimated actuarial values for the CHIP benefit plan and the benchmark plans are presented in Exhibit C. For comparison purposes we also included values for the Medicaid benefit plan. The amounts shown are per child per month. It should be noted that although the BBA places relatively strict limitations on the amount of cost sharing that can be incorporated into a CHIP plan, it allows for the recognition of the cost associated with removal of cost sharing provisions by allowing certain benefits to be eliminated from the CHIP plan with an aggregate actuarial value equal to the value of the cost sharing which was removed.

Since each of the benefit plans valued on Exhibit C provides comprehensive coverage, the actuarial values fall into a relatively narrow range if cost sharing is ignored. In fact, the principal difference among the plans results from inclusion of comprehensive dental coverage in the Medicaid benefit plan while less generous dental coverage is provided under CHIP and FEHBP and no dental coverage is provided in UGIP HealthSelect or UGIP HMO.

Based on the information summarized in Exhibit C, the CHIP benefit plan satisfies the requirements of BBA Section 2103(a)(2) for benchmark-equivalent coverage.

Exhibit D presents a projection of the cost for each of the benefits provided under the CHIP benefit plan for

each of the covered populations. The cost projections were determined assuming a traditional Medicaid fee-for-service delivery system and reimbursement methodology. The cost projections shown on Exhibit D include no amounts for administrative expenses.